MEDICARE LEARNING NETWORK -
COMPUTER/WEB-BASED TRAINING

FRAUD AND ABUSE

Welcome to the Medicare Fraud and Abuse course!

Billions of taxpayer dollars are lost annually to healthcare fraud and abuse! It is estimated that 10% of Medicare costs are wrongly spent on fraud and abuse incidents.

Medicare and the federal government are aggressively dealing with these issues and ask for your help, as a health care provider, to identify and prevent inappropriate behavior.

The purpose of this course is to give you the knowledge and skills needed to detect and prevent Medicare fraud and abuse.

You will learn:

- What Medicare fraud/abuse is - and isn't
- Safeguard measures to help you protect yourself against fraud, waste and abuse.
- Liability guidelines when encountering Medicare fraud or abuse

Before we start this course, let's understand its organization and tools.

1. This course is approximately 60 minutes in length and can be taken at your own pace.

2. The course begins with a short Preliminary Knowledge Assessment. After taking the Assessment, you will proceed to the main menu for the course where you can access the lessons and the Post-Course Knowledge Assessment.

3. Elaine, our Medicare expert, will accompany you through most of this course to facilitate your understanding of key issues. Click her now to see how this works.

Hi, my name is Elaine. I have 10 years of experience working for Medicare on fraud and abuse issues. I will help you at various points in the course and provide feedback and explanations about topics related to Medicare fraud and abuse.

In addition to screen text and images used to present information, you will see a Print button on certain screens which allows you to print the course's safeguard materials.

After clicking the Print button, a document will be sent to a local printer if there is one connected to the computer from which you are viewing the course.

There may also be other images throughout the course that you can click for more information. Be sure to read the prompt line for instructions.

Let's take the Preliminary Knowledge Assessment to determine how much you already know about Medicare fraud and abuse.

This brief assessment asks you to answer a series of questions on issues relating to fraud and abuse. Assessment feedback is given after you have answered all 14 questions to help you understand your level of knowledge of the course subject matter.

You can begin the course lessons once the entire Preliminary Knowledge Assessment has been completed.

! IMPORTANT !

Make sure you select an answer on each screen before clicking the Right Arrow button to continue. You are not allowed to go back to screens in the Preliminary Knowledge Assessment and any screens without an answer selected will count as incorrect.

Define Medicare Fraud:

Which of the following is the correct definition(s) of Medicare fraud?

- Knowingly executing a scheme against the Medicare program
- Attempting a scheme against the Medicare program
- Willfully executing an artifice against the Medicare program
- All of the above

Define Medicare Abuse

Which of the following is the correct definition of Medicare abuse?

- Knowingly defrauding the Medicare program
- Unknowingly violating Medicare guidelines
- Intentionally violating Medicare guidelines
- None of the above

Has Medicare fraud or abuse occurred if a provider is charging a patient for non-covered service?

- Yes
- No

Has Medicare fraud or abuse occurred if a provider is continually submitting duplicate claims to the Medicare program?

- Yes
- No

Has Medicare fraud or abuse occurred if a provider collects more than the 20% of the co-insurance from a patient from an unassigned claim?

- Yes
- No

Is the Violation Fraud or Abuse?

A provider requires a deposit from a beneficiary as a condition for continued care.

- Fraud
- Abuse

Is the Violation Fraud or Abuse?

A provider intentionally upcodes services to a higher level in order to receive a larger reimbursement from Medicare.

- Fraud
- Abuse

Provider liability:

Is a provider financially liable if his/her billing service commits fraud without the provider's knowledge?

- Yes
- No

Provider liability:

Are providers liable for all claims submitted on their behalf which contain their Medicare identification number?

- Yes
- No

Penalties associated with Medicare Fraud and Abuse:

What can happen to you if you are suspected of Medicare abuse?
(Choose all that are correct.)

- You can be obligated to participate in provider education initiatives.
- Your assignment privileges can be revoked.
- Medicare can exclude you from the entire Medicare program.
- You can be imprisoned.
- All of the above.

Safeguard Practices against Fraud and Abuse:

When implementing safeguard practices to prevent Medicare fraud and abuse, I should keep the following in mind:
(Choose all that are correct.)

- Ensure that my Medicare provider number is noted on all documents for all staff to see to verify my Medicare provider status.

- Make sure Medicare guideline information is regularly circulated among appropriate claim and billing staff and implemented in systems.

- Make sure that an ABN (Waiver of Liability) is being provided to patients for all services performed.

- Confirm that all employees or providers hired or contracted with are not on the Sanctioned Provider List.

When selecting a billing service to use, I should choose a service that: (Choose all that are correct.)

- Charges for their service on the basis of the number of claims they file rather than at a single monthly rate.
- Guarantees the confidentiality of my Medicare provider number and other personal information.
- Charges patients the appropriate amount for services rendered by the provider.
- All of the above.

When selecting a laboratory to use, I should choose a lab that:
(Choose all that are correct.)

- Uses test request forms which allow me to order profiles and panels only, rather than individual tests.
- Does not change diagnosis codes on the original test request form or patient's "buckslip."
- Monitors the test request forms to ensure a diagnosis code defining the reason why each test was ordered.
- All of the above.

When implementing safeguard practices to protect my patients from Medicare fraud and abuse, I should do the following:

- Share Medicare beneficiary identification numbers freely with all staff and other healthcare providers with whom I work.
- Share Medicare beneficiary fraud information with my patients which is published and distributed by the Medicare contractor.
- Ensure that the patient number used on the Medicare claim form is taken from old files for the patient.

Good try! You scored ____ correct on the Preliminary Knowledge Assessment.

It is advised that you proceed through all course lessons beginning with the first lesson to increase your understanding of Medicare fraud and abuse.

1	2	3	4	5	6	7	8	9	10	11	12	13	14

The following course lessons provide a detailed explanation of fraud and abuse guidelines and scenarios. Printed safeguard checklists are offered to assist your healthcare business safety.

Take the Post-Course Knowledge Assessment after you have completely reviewed all of the course lessons.

Learn about Medicare fraud and abuse from the following lessons:

- What is Medicare Fraud and Abuse?
- Identifying Medicare Fraud and Abuse
- Liability and Penalties of Fraud and Abuse
- Safeguard Practices Against Fraud and Abuse
- Reporting Medicare Fraud and Abuse
- Post-Course Knowledge Assessment

What is Medicare Fraud and Abuse?

After completing this lesson, you should be able to:

- Define Medicare Fraud
- Define Medicare Abuse

Protect your practice from Medicare Fraud and Medicare Abuse.

Your first step in protecting yourself is to understand the legal definitions of these two terms.

Medicare Fraud is legally defined as:

"Knowingly and willfully executing, or attempting to execute a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program."

Medicare Abuse is legally defined as:

"Abuse may, directly or indirectly, result in unnecessary costs to the Medicare or Medicaid program, improper payment for services which fail to meet professionally recognized standards of care, or that are medically unnecessary."

And

"Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment."

Additionally…

Inappropriate actions or behaviors against the Medicare program which are identified by the provider but are not remedied may be considered fraudulent by Medicare. It is expected that all health care providers who participate in the Medicare program furnish and report services in accordance with the established regulations and policies.

"Knowingly and willfully executing, or attempting to execute a scheme or artifice against the Medicare program."

Is the correct definition for which of the following terms?

- Fraud
- Abuse

The correct definition(s) of Medicare abuse is(are):

- To knowingly and willfully execute or attempt to execute a scheme or artifice against the Medicare program.

- To unknowingly or unintentionally obtain payment for items or services when there is no legal entitlement to the payment.

- To fail to meet professionally recognized standards of care or furnishing medically unnecessary services or items.

Identifying Medicare Fraud and Abuse

After completing this lesson, you should be able to:

- Recognize the four most common types of Medicare fraud.

- Recognize the three most common types of Medicare abuse.

- Correctly determine whether a violation of Medicare fraud or abuse has occurred, given a violation scenario.

You should be aware of the most common types of Medicare fraud.

Four most common types of Medicare fraud:

1. Billing for services that were not rendered.

2. Misrepresenting as medically necessary, non-covered or screening services by reporting covered procedure/revenue codes.

3. Signing blank records or certification forms or falsifying information on records or certification forms for the sole purpose of obtaining payment.

4. Consistently using procedure/revenue codes that describe more extensive services than those actually performed.

Now let's look more closely at these types of fraud.

1. Billing for services that were not rendered.

Fraud scenario: A clinical laboratory receives orders from a physician for specific clinical laboratory tests. The lab performs and bills for the tests indicated on the order, but then also bills for additional tests that were not ordered nor rendered.

Fraud scenario: A patient recruiter convinces unsuspecting beneficiaries to reveal their Medicare numbers to him. The recruiter then sells the Medicare numbers to a fictitious provider who, in turn, bills for services/items which were never furnished.

Providers should ensure that only the services/items they order are furnished.

2. Misrepresenting as medically necessary, certain non-covered screening services, by reporting covered procedure/revenue codes.

Fraud scenario: A group of nursing home patients are offered free exercise and/or social activities. However, the free services are billed to Medicare as covered Partial Hospitalization services at a Community Mental Health Center or as covered physical therapy at a rehabilitation facility.

3. Signing blank records or certification forms or falsifying information on records or certification forms for the sole purpose of obtaining payment.

Fraud Scenario: A Durable Medical Equipment supplier has a financial arrangement with a physician who completes Certificates of Medical Necessity for patients he has never treated. The completed CMNs are used to falsely document the medical necessity of equipment given to patients who do not need the equipment.

Fraud Scenario: A physician unwittingly signs blank certification forms for a home health agency that falsely represents that skilled nursing services are needed for patients who would not have qualified for home health services.

Both providers in this scenario, the physician and Durable Medical Equipment company, are committing Medicare fraud. The physician committed fraud by signing incomplete or blank prescription forms, and the Durable Medical Equipment company committed fraud by filing false prescriptions for the purpose of obtaining Medicare payment. In addition, they are in direct violation of the Anti-kickback Statute, along with other various laws, etc.

4. Consistently using procedure/revenue codes that describe more extensive services than those actually performed.

Fraud Scenario:
A physician routinely bills for high-level evaluation and management services procedure codes although many of the visits he furnishes do not meet the requirements for the codes reported.

Fraud Scenario:
A hospital falsely reported pneumonia as the diagnosis for a majority of the inpatient hospital stays billed to Medicare. As a result, their DRG payment was significantly higher than it should have been.

Identify an example(s) of when a provider bills for procedure/revenue codes that describe more extensive services than were actually performed (i.e., upcoding):

- A radiologist routinely bills for chest x-rays with two views, although most of the chest x-rays performed are for single views.

- A fictitious provider bills for services that were never furnished.

- A physician uses a non-physician practitioner to perform follow-up visits, but bills the practitioner's services as comprehensive initial evaluations.

Identify an example(s) of when a provider misrepresents as medically necessary, non-covered or screening services:

- A home health agency bills for covered home health services for an unqualified patient.
- An ambulance company bills for emergency transportation for scheduled trips from a nursing home to a clinic.
- A physician falsifies the diagnosis for a service which would otherwise be denied coverage if it were correctly reported.

Identify the correct definition of non-rendered services.

- Services/items furnished to a patient but not billed to Medicare.
- Non-covered services under Medicare.
- Services/items NOT furnished to a patient but billed to Medicare.

Which type of Medicare fraud is committed by the provider in the following scenario?

Scenario: A physician signs blank certification forms for a supply company so that the supply company can bill and be paid for durable medical equipment that is falsely documented.

- Consistently using procedure/revenue codes that describe more extensive services than those actually performed.
- Signing or falsifying information on records or certification forms for the sole purpose of obtaining payment.
- Misrepresenting as medically necessary non-covered or screening services.
- Billing for services that were not rendered.

Be aware of other types of Medicare fraud:

1. Using an incorrect or invalid provider number in order to be paid or to be paid at a higher rate of reimbursement.
2. Selling or sharing Medicare health insurance claim numbers so that false claims can be filed to Medicare.

3. Routinely waiving co-insurance and/or deductibles for Medicare patients when no effort has been made to collect the amounts due or when the patient DOES have the ability to pay.

4. Falsifying information on applications, medical records, billings statements, and/or cost reports, or on any document filed with the government.

5. Offering, accepting, or soliciting bribes, rebates or kickbacks.

Which type of fraud was perpetrated in the following scenario:

Scenario: A mobile diagnostic company hires physicians to interpret reports of tests performed on nursing home patients. (Note that Medicare guidelines restrict coverage of these tests to office or hospital settings with direct physician involvement.) The mobile diagnostic company then uses the physician's Medicare number to bill for the tests as if they were furnished in the physician's offices.

- Selling or sharing a patient's Medicare number so false claims can be filed to Medicare.

- No fraud was perpetuated by the provider in this scenario.

- Using an incorrect or invalid provider number in order to be paid or to be paid at a higher rate of reimbursement.

Which type of fraud was perpetrated in the following scenario:

Scenario: A nursing home administrator is paid a "referral fee" for allowing a Community Mental Health Center representative to provide free social activities to the nursing home's Medicare beneficiaries Also, the beneficiaries are given free meals and shoes for participating in the activities. However, the free services are billed to Medicare as group psychotherapy.

- Consistently not collecting the 20% co-insurance or waiving the co-insurance to induce services.

- Falsifying information on applications, medical records, billing statements, and/or cost reports, or on any statement filed with the government.

- Offering, accepting, or soliciting bribes, kickbacks, or rebates.

Now that we are familiar with the most common types of Medicare fraud, let's identify how Providers often abuse the Medicare program.

Common types of Medicare abuse:

1. Billing for services/items in excess of those needed by the patient.

2. Routinely filing duplicate claims, even if it does not result in duplicate payment.

3. Inappropriate or incorrect information filed on cost reports.

Note: Although inappropriate billing or reporting may initially appear abusive, they could evolve into fraud.

Let's look at these types of Medicare abuse in more detail.

1. Billing for services/items in excess of those needed by the patient.

Abuse Scenarios: Laboratory equipment is calibrated to run additional indices with every CBC test. Physician orders may only be for a CBC, but claims filed to Medicare include charges for the CBC and the additional indices.

A hospital has a standard protocol which requires all patients admitted through the emergency room to have the following tests performed, regardless of the patient's condition: EKG, chest x-ray, urinalysis, and lab panel.

2. Routinely filing duplicate claims, even if it does not result in duplicate payment.

Abuse Scenario: A provider's electronic billing program automatically refiles their claims if payment is not received within a three-week period from the submission date.

3. Inappropriate or incorrect information filed on cost reports.

Abuse Scenarios: A hospital reports salaries paid to its administrators that have been determined to be excessive in prior cost report settlements.

An Outpatient Rehabilitation Facility includes non-covered charges in its "allowable costs" section of the cost report.

Identify the type of abuse that occurred in the following scenario:

Scenario: A durable medical equipment supplier delivers and bills for a wheelchair with several accessories. However, the physician's order only required a standard wheelchair.

- Billing for services in excess of those needed by the patient.
- Intentionally or unintentionally filing duplicate claims to the Medicare program, even if it does not result in duplicate payment.
- Collecting more than the 20% co-insurance or the deductible on claims filed to Medicare.

Identify which of the three scenarios is an example of Medicare program abuse by, "routinely filing duplicate claims to Medicare."

- Dr. John Doe billed Medicare for a high level E&M visit when a lower level visit was actually performed.
- Dr. John Doe has a billing service which he pays to file Medicare claims for him based on the number of claims filed. The billing service often resubmits claims to Medicare which result in a denial letter to the doctor indicating that claims were denied for duplicate submission.
- Dr. John Doe regularly demanded his Medicare patients pay a 25% Medicare co-insurance before services could be rendered.

Identify which of the following scenarios is an example of abuse by "reporting inappropriate or incorrect information on cost reports."

- Billing for costs not incurred or which were attributable to nonprogram activities, other enterprises, or personal expenses.
- Using depreciation methods that have not been approved by Medicare.
- Improperly reporting days (inpatient stays) that may result in an overpayment.

Other common types of Medicare Abuse are:

1. Collecting in excess of the deductible or coinsurance amounts due from a patient.

2. Requiring a deposit or other payment from a patient as a condition for admission, continued care, or other provision of services.

3. Unbundling or "exploding" charges (e.g., reporting a series of codes when there is one specific code which describes and includes payment for all components of the series of codes).

Identify the type of abuse that occurred in the following scenario:

Abuse Scenario: A series of diagnostic tests are each reported separately. However, there is a single procedure code which describes all of these services.

- Unbundling or "exploding" charges.
- Billing for non-covered services.

Liability and Penalties of Fraud and Abuse

After completing this lesson, you should be able to:

- Recognize the extent of your liability as a Provider for Medicare fraud and abuse.

- Identify the criminal and civil penalties imposed on individuals who are convicted of committing Medicare fraud.

- Identify the four administrative sanctions Medicare contractors impose on individuals who are abusive to the Medicare program.

An important step in protecting yourself from Medicare fraud and abuse is knowing when and how you are liable as a Provider.

Keep these three points in mind when considering your liability:

1. Providers are liable for Medicare fraud when their intent to purposely obtain money or property owned by Medicare through false or fraudulent pretenses has been clearly determined.

2. Providers are liable for Medicare abuse for all claims submitted that violate the Medicare program guidelines.

3. Providers may also be held responsible for fraudulent or abusive claims submitted where they are noted as the "Referring Physician" for the service performed such as claims submitted by clinical laboratories.

Now, let's look at scenarios which demonstrate how Providers can be liable for Medicare fraud and abuse.

Understanding your liability as a Provider will protect you from Medicare fraud and abuse. Physicians, medical equipment suppliers, clinical laboratories, other health care providers, and beneficiaries may be potential candidates for harming you.

Provider Liability Cases

Scenario:

An external billing service set up as the payee of the Provider (on Medicare's file) commits fraud by billing for additional services not rendered by the Provider.

Is the Provider liable?

The Provider would be liable for the Medicare fraud committed by the billing service in this case if his/her intent to commit fraud had definitely been established by the results of an investigation. If so, the Provider would be responsible for returning all overpayments to Medicare.

Scenario:

An employee of a provider commits fraud without the provider knowing it.

Is the Provider liable?

All providers are responsible for the actions of their employees. Prosecution of the provider in this case for his/her employee's Medicare fraud is unlikely if the Provider's lack of intent has been definitely established by the results of an investigation. The Provider will be responsible for returning all overpayments to Medicare.

Scenario:

A physician refers a patient to another provider for diagnostic tests. The other provider bills medically unnecessary services as covered services for the referred patient.

Is the referring physician liable?

The referring physician, in this case, is not liable for the other provider's Medicare fraud as long as his/her referral information concerning the medical necessity for the test is appropriately documented.

Scenario:

A provider uses incorrect billing procedures when billing Medicare for services which result in overpayment by Medicare. Billing and coverage of the procedure is published by the Medicare contractor.

Is the Provider liable?

Providers are responsible for incorrect billing practices. Providers are expected to correct mistakes and return overpaid monies to Medicare. If providers fail to correct mistakes and return overpaid monies, they may be suspected of fraud.

A provider's actions may be considered fraudulent and the provider would be considered liable if:

- Claims are submitted which contain mistakes resulting in an overpayment.
- Claims are submitted in which the provider intentionally "upcoded" charges.
- Claims are submitted which contain mistakes resulting in an overpayment that the provider identifies but does not correct the errors.

A provider's actions may be considered fraudulent or abusive and the provider may be considered liable in which of the following scenarios?

- A billing service uses the Provider's Medicare number to bill for non-rendered services without the Provider knowing it.

- The Provider signs blank prescription forms for a medical supply company so that the company may bill Medicare for non-rendered services. The Provider receives kickbacks from the company for the signed forms.

- The Provider's employee independently re-submits 60 claims to Medicare 15 days after initially submitting the same claims as she was unsure which claims actually were sent.

Now let's look at how Medicare fraud and abuse cases are identified and penalized:

Suspected cases of fraud and abuse are identified and investigated through a coordinated network of federal and state agencies and local Medicare contractors.

The Office of the Inspector General (OIG) is primarily responsible for Medicare fraud investigations and provide support to the U.S. Attorney's Office for cases which lead to prosecution. In addition, the OIG coordinates their efforts and other entities such as the Federal Bureau of Investigation, the Internal Revenue Service, Medicaid, other state agencies, and, of course, Medicare contractors.

Medicare contractors participate in the fight against fraud, waste, and abuse by referring potential cases of fraud to law enforcement and by preventing and detecting fraud and abuse through education, review of claims and cost reports, and coordination with other organizations.

Law enforcement agencies can investigate and prosecute for fraud.

- Criminal Prosecution:

The U.S. Attorney's Office may use a series of federal statutes to indict and prosecute individuals and/or entities involved in fraud. Those found guilty may be subject to substantial penalties, fines, and restitution as well as imprisonment.

- Civil Prosecution

In lieu of criminal prosecution, the U.S. Attorney's Office may decide that the interests of the Medicare program are best served through the civil courts. In these cases, individuals and/or entities also face substantial penalties for each violation of program rules, including repayment of up to three times the amount of damages to the Medicare program and large fines.

In either case, individuals and/or entities may be excluded from participating in any federal health care program for a specified period or indefinitely. In addition, practitioners may have their licenses revoked by the state.

The Department of Health and Human Services (DHHS), which include the HCFA and OIG, has the authority to impose remedial action or administrative "Sanctions" against individuals who consistently fail to comply with Medicare law or are deemed abusive to the Medicare program.

Sanctions include:

- Provider education and warning.
- Revocation of Assignment privileges.
- Withholding of Provider's Medicare payments and recovery of Medicare's overpayments.
- Exclusion of Provider from the Medicare program. Posting of Provider name on national Sanctioned Provider list that is sponsored by the U.S. government.

What are the penalties that may be imposed on individuals and/or entities who are convicted?

- Loss of Medical License.
- Criminal penalties, fines, restitution, and/or imprisonment.
- Civil penalties, plus triple damages.

A provider consistently billed for services in excess of those needed by her patients. What are the possible actions that can be imposed for her action?

- Withholding of her Medicare payments and the recovery of Medicare's overpayment
- Civil penalties including assessments per violation.

- Provider education and warning
- Revocation of her Assignment privileges.
- Exclusion of Provider from the Medicare program

Did you know that Providers commit 80% of the existing cases of Medicare abuse and 90% of the Medicare fraud cases?

It is in your best interest to implement as many safeguard practices as possible to prevent the occurrence of Medicare fraud and abuse.

- Abusive Medicare program behavior costs your business money in the form of refilling costs and may be considered fraudulent by Medicare if not remedied.
- Fraudulent behavior committed in association with your medical business can result in severe monetary and legal penalties for your business depending on the level of your intentional wrongdoing.

Now, let's look at ways to safeguard against fraud and abuse.

Physicians, medical equipment suppliers, clinical laboratories, beneficiaries, and other health care providers are all likely candidates for committing Medicare fraud and abuse. Protect yourself by understanding how you are vulnerable and who is a potential violator of the Medicare program.

Gain helpful Safeguard practices from the following topics:

- Fraud and Abuse in your Office
- Billing Services Fraud and Abuse
- Patient Safety in Clinics
- Safeguarding Beneficiaries
- Optional Vulnerability Self Check

Fraud and Abuse in your Office

Safeguarding against Medicare fraud and abuse in your practice begins by making sure you have systems in place to follow Medicare guidelines.

When providing services to Medicare beneficiaries, you are responsible as a provider to abide by the three Medicare Payment Premises. These premises are:

1. Recognize what services are covered by Medicare.

2. Recognize what services are medically necessary and reasonable for the treatment of the patient's condition.

3. Document and properly report services according to Medicare guidelines and procedures.

There are a variety of resources to assist your compliance with the three Medicare Payment Premises. These resources are:

1. Medicare coverage and policy guidelines, documentation requirements, and reimbursement rules are listed and explained in publications from Medicare contractors and the Federal government. Many of these publications are available on bulletin board systems and/or websites.

2. The American Medical Licensing Board code of standards serves as the primary reference to all physicians and healthcare Providers in the U.S. when determining the medical necessity of care for a patient's medical condition.

3. Provider education and Medicare safeguard guidelines are offered by Medicare contractors to all providers enrolled in the program to assist their documentation and reporting practices of medical services.

Medicare suggests Providers implement quality checks, internal audits, and ***safeguard practices*** *in their offices to ensure that they are correctly following all three of the Medicare Payment Premises.*

Let's look at the key safeguards you should implement in your office to protect yourself from fraud and abuse.

You can maintain provider number confidentiality by:

1. Making sure your Medicare Provider Number is not noted on documents unrelated to Medicare claim filing.

2. Ensuring that all staff who bill on your behalf understand the need for confidentiality. Have billing staff sign a disclosure statement regarding your Medicare Provider Number or implement alternative numbering systems for provider identification in your office.

3. Maintaining copies of all claims where your Provider Number is used for referrals.

The second safeguard against Medicare fraud and abuse is to make sure your staff understands and follows Medicare guidelines and procedures.

Your office can follow Medicare guidelines and procedures by:

1. Ensuring that there is a process in place to check claim remittances prior to re-filing claims.

2. Implementing standard operating procedures to ensure that proper guidelines are being followed.

3. Assessing how well existing and new Medicare guidelines and policies are disseminated among appropriate departmental areas, including billing and accounting staff.

Finally, you can prevent possible Medicare fraud and abuse initiated by your employees.

Two safeguard which may prevent intentional or unintentional fraud and abuse are:

1. Determine employee performance evaluation ratings by claim-filing accuracy, NOT by the number of claims filed.

2. Consult Sanctioned Provider Lists before hiring, contracting with, or conducting business with another provider. One resource for these lists is the Government Services Administration Debarment, Exclusion Suspension Lists website (*www.ARNET.gov/epls*).

Safeguard Practices against Fraud and Abuse for your Office

** Keep your Medicare Provider number confidential:*

1. *Make sure your Medicare Provider number is not noted on documents unrelated to Medicare claim filing.*

2. *Ensure that all staff who bill on your behalf understand the need for confidentiality. Have billing staff sign a disclosure statement regarding your Medicare Provider number or implement alternative numbering systems for provider identification in your office.*

3. *Maintain copies of all claims where your Provider number is used for referrals.*

**Make sure your office follows Medicare guidelines and procedures:*

1. *Ensure there is a process in place to check claim remittances prior to re-filing claims.*

2. *Coordinating the implementation of new Medicare guidelines and policies through the development of standard operating procedures and/or the development of systematic mechanisms.*

3. *Assessing how well existing and new Medicare guidelines and policies are disseminated among appropriate departmental areas, including billing and accounting staff.*

**Prevent possible Medicare fraud and abuse initiated by your employee in two ways:*

1. *Determine employee performance evaluation ratings by claim-filing accuracy NOT by the number of claims filed.*

2. *Consult Sanctioned Provider Lists before hiring, contacting with, or conducting business with another provider to your practice: Government Services Administration Debarment, Exclusion, Suspension Lists (www.ARNET.gov/epls/).*

Safeguard Practices Against Fraud and Abuse

Fraud and Abuse in your Office

Match each Medicare Payment Premise with its correct safeguard resource:

Recognize what services are covered by Medicare.	American Medical Licensing Board code of standards
Recognize what services are medically necessary and reasonable for the treatment of the patient's condition.	Medicare and federal government publications which delineate Medicare covered services
Document and properly report the service according to Medicare guidelines and procedures.	Provider education and Medicare safeguard guidelines offered by Medicare Contractor

Match the Payment Premise with its correct resource, then click Done.

Choose the correct practices to use for maintaining confidentiality of a Medicare Provider Number:

- Make sure your Medicare Provider Number is not noted on documents unrelated to Medicare claim filing.
- Allow medical supply companies to use blank forms with the Provider's signature.
- Document referrals of all claims where your Provider Number is used.
- Follow up on billings and reimbursement.
- Ensure all staff, who bill on your behalf, understand the need for confidentiality.

Choose the correct safeguards to protect a provider's office from Medicare Fraud and Abuse:

- Determine employee performance evaluation ratings by claim filing quantity.
- Consult Sanctioned Provider Lists before hiring, contracting with, or conducting business with another provider.
- Resubmit all claims filed to Medicare before checking claim remittance status with your Medicare contractor.
- Assess how well existing/new guidelines and policies are disseminated throughout your organization.
- Coordinate the implementation of new guidelines and policies.

Billing Service Fraud and Abuse

Let's look at safeguards against fraud and abuse committed by billing services.

You can safeguard against billing service fraud and abuse by:

1. Carefully selecting your billing service.
2. Agreeing to a sensible contract of work with the billing service.
3. Regularly monitoring the services and performance of the billing service.

When selecting a billing service for your practice, verify that the service has the following criteria:

1. Service has a reputable past experience billing Medicare claims. Check references from other Providers and the Better Business Bureau.
2. Service's electronic filling system/program is compatible with Medicare (NSF or ANSI formats).
3. Service performs extensive claim edits which check all claims prior to their submission to Medicare for invalid diagnosis and procedure codes, duplicate claims, and unbundled procedures.

Your contract of work with a billing service should ensure that the following guidelines are met:

1. Payment for the billing service is set at a single rate rather than based on the number of claims filed by the service.

2. All correspondence with Medicare to the billing service will be forwarded to your practice.

3. Records of claims submitted on your behalf will be kept by the billing service for seven years.

4. Your Medicare provider number and personal information will be protected by the billing service.

You should regularly check the accuracy of claims submitted by your billing service to ensure that Medicare fraud and abuse is not occurring.

Check the accuracy of records and claim receipts for claims submitted by your billing service by confirming that:

1. Procedure, diagnosis, and/or revenue codes were not altered prior to submission to Medicare.

2. Services were not inappropriately unbundled.

3. Patients were charged the appropriate amount.

Choose the correct criteria that a billing service should support.

- Extensive claim edits which check all claims prior to submitting to Medicare for invalid diagnosis and procedure codes, duplicate claims, unbundled procedures.

- Capability to complete a Medicare claim form and enter diagnosis codes for Provider when needed.

- Reputable past experience billing Medicare claims.

- Capability to file and remit claims electronically to Medicare (NSF or ANSI formats).

A contract of work with a billing service should contain which of the following conditions to ensure that the service is not able to commit fraud and abuse with your claims?

- Medicare Provider number and personal information will be protected by the billing service.
- Records of claims submitted on your behalf will be kept by billing service for seven years.
- Correspondence from Medicare to the billing service will not be forwarded to your practice.
- A condition that their system/program is compatible with Medicare, if the service files claims electronically.

Patient Safety in Clinics

Physicians are entrusted with and expected to engage in activities that promote the health and well-being of their patients.

When a physician's name, license, or provider number are used - with or without the physician's knowledge - to take advantage of patients and health care programs, it becomes a concern to the health care industry. In particular, a physician who reassigns benefits to another entity may be at risk of having false claims filed with their Medicare provider number, with or without the physician's knowledge.

Example: A legitimate claim may be filed using the physician's provider number, but then additional services are billed which were not rendered by the physician or under the physician's supervision. In addition, claims may be filed for services furnished by unlicensed or unqualified individuals. Or, false claims for services which are not furnished or for patients who were not seen by the physician may be filed using the physician's Medicare provider number.

When reassigning benefits to another individual or entity, physicians should:

- Ensure that services which are furnished under the supervision of the physician are furnished by individuals who are appropriately qualified and/or licensed.

- Ensure that the physician is allowed access to all information and records regarding claims which are filed on their behalf.

- Periodically review billing records to ensure the legitimacy of claims filed on their behalf.

- Ensure that there are processes in place which guarantee the confidentiality of their Medicare provider number and their patients' health insurance information.

- Ensure that only authorized individuals file claims on their behalf.

Safeguarding Beneficiaries

Safeguarding your patients against fraud is important for their safety and well-being.

- Protect yourself from losses when services/items are furnished to Medicare beneficiary "imposters" by verifying their identities.

- Protect your patients against fraud by maintaining the confidentiality of their Medicare numbers and medical records.

Let's look closely at the suggested ways to prevent fraud against your patients.

The most common types of beneficiary fraud occur when a patient's Medicare number is sold or stolen and then used to gain illegal money or services from the Medicare program. Beneficiary fraud can occur with or without the patient's voluntary participation in the scheme.

Protect your patients against Medicare fraud by carefully assessing patient Medicare identification.

Follow these guidelines when checking in your patients:

1. Ensure that the Health Insurance Claim number used to file claims is taken from the patient's red, white, and blue Medicare card.

2. Confirm that the name on the Medicare card matches the patient's valid photo identification.

Protection of patient Medicare numbers would abolish a large majority of the fraud problems experienced by Medicare contractors throughout the United States.

What are the most common type(s) of beneficiary fraud?

- Patient's Medicare Number is lost, stolen or sold and then used to gain illegal money or services from the Medicare program.

- Medicare Provider Number is sold and used to bill Medicare for unrendered services.

- Patients become "professional patients". That is, they seek out medically unnecessary health care services/items in exchange for a fee.

What are the correct guidelines for assessing patient Medicare identification for assessing patient Medicare identification for a Medicare Part A or a Medicare Part B provider?

- Allow patients to give you their Medicare identification number without showing their Medicare card.

- Ensure that the Health Insurance Claim number reported on claims is taken from the patient's red, white, and blue Medicare card.

- Confirm that the name on the Medicare card matches the patient's valid photo identification.

Optional Vulnerability Self Check

Complete the following self check to learn how protected your practice is from Medicare fraud and abuse. Part A and Part B Providers should take both the General Self Check and the self check relevant to their medical business type.

General Self Check

When disposing of records, do you shred or otherwise destroy reports that include patients' names and Medicare numbers?

- Yes
- No

Do you advertise that you will waive Medicare coinsurance/deductible amounts or that the patient will "owe nothing" even if they do not have a Medicare supplement?

- Yes
- No

Do you review the reports of sanctioned individuals and entities to assure that those individuals and/or entities are not employed by or contracted with you, or that you are not doing business with them?

- Yes
- No

Is your provider number kept confidential and shared only with those with an operational need to know?

- Yes
- No

Do you carefully review all documentation before certifying the medical necessity of services or supplies needed by your Medicare patients?

- Yes
- No

If you have authorized someone else to bill Medicare for your services, do you have a process in place to ensure those billings accurately reflect the services furnished?

- Yes
- No

Have you done proper background checks on companies and people you have contracted with or hired in connection with your Medicare business?

- Yes
- No

Do you have a process in place to effectively keep up with changes in Medicare's guidelines and policies?

- Yes
- No

Do you periodically check to ensure that services you order for patients are the only ones actually performed and billed to Medicare?

- Yes
- No

Do you notify Medicare and/or the state licensing agency prior to making any changes to the location of your business?

- Yes
- No

Do you personally read and understand all agreements and contracts related to your Medicare business before signing them?

- Yes
- No

Do you document fully the services you bill to Medicare, and do you have a process for maintaining your records?

- Yes
- No

Do you allow billing staff to make changes to the billing record without the appropriate approval?

- Yes
- No

Have you examined all your business relationships for any conflicts with the Stark/self referral and anti-kickback provisions?

- Yes
- No

Do you have internal audits in place to detect billing inaccuracies promptly?

- Yes
- No

Self Check for Part A Providers

Do you have a system in place to identify patients receiving outpatient services within 72 hours of an inpatient stay?

- Yes
- No

Do you have a system in place to identify patients receiving outpatient services within 72 hours of an inpatient stay?

- Yes
- No

Are the appropriate outpatient charges/codes combined with those for inpatient services?

- Yes
- No

Do you verify that the devices purchased and used by your facility have received approval from the Food and Drug Administration (FDA)?

- Yes
- No

Do you audit the medical record discharge status with that on the patient bill?

- Yes
- No

As a Medicare SELECT provider, do you continue to charge the Medicare inpatient deductible for patients in exempt psychiatric and rehabilitation units paid under TEFRA?

- Yes
- No

If a patient receives the implant of an investigational device during an otherwise medically appropriate admission, is the surgical procedure to implant the device included in the coding for the DRG?

- Yes
- No

Does your charge master include non-covered services under the Medicare program with a revenue code that is covered?

- Yes
- No

Do you bill the Medicare program for self-administrable drugs provided to hospital outpatients?

- Yes
- No

Do you have a policy in place that ensures pre-operative services are performed within the appropriate window for inpatient bundling?

- Yes
- No

Do you have a process in place that identifies if canceled services are charged to the patient account?

- Yes
- No

Do you have a program set up that requires periodic and re-credentialing of your medical staff?

- Yes
- No

Self Check for Part B Providers

Have you informed Medicare if your physical address or phone number has changed for either your primary provider number or for any of your suffixes?

- Yes
- No

Do you have a process in place to ensure that the diagnoses reported on your claims can be linked to the medical documentation in the patient's records?

- Yes
- No

Do you question lab requisition forms that list only "panels" and do not list the specific tests you need individually?

- Yes
- No

Do you ever sign blank forms like certificates of medical necessity?

- Yes
- No

Do you monitor your lab test results to ensure they are consistent with the tests you ordered?

- Yes
- No

Do you have processes in place to ensure that the procedure codes that you bill for are documented in your patient's medical records?

- Yes
- No

When you bill for "incident to" services, do you ensure that ALL requirements of the "incident to" provision are met?

- Yes
- No

Do you ever advertise "free" services that are subsequently billed to Medicare?

- Yes
- No

Do you pay your billing service based on an "incentive" arrangement?

- Yes
- No

Lesson: Reporting Medicare Fraud and Abuse

You can protect yourself and the Medicare program by reporting any suspected cases of fraud or abuse to the appropriate Medicare authorities.

Direct your reports to your Medicare Contractor or to the OIG's Fraud Hotline. Reports to these numbers can be anonymous.

1. Local/Regional Medicare contractor Customer Service Department, Fraud Department, or Fraud Hotline number.

2. 1-800-HHS-TIPS, OIG's Fraud Hotline number

You should provide the following types of information when reporting a suspected case of Medicare fraud or Medicare program abuse:

1. Patient name
2. Patient health insurance claim number
3. Date(s) of service
4. Description of service/item
5. Name of Provider
6. Address of Provider
7. Provider's Medicare number
8. An explanation or description of the alleged fraudulent or abusive activity

Choose the correct resources available to use when reporting suspected cases of Medicare fraud and abuse.

- Medicare contractor Customer Service Dept., Fraud Dept., or Fraud Hotline
- OIG's Fraud Hotline, 1-800-HHS-TIPS
- Federal Safety Administration

Choose the types of information which can be used to report suspected fraud or abuse.

- Patient Name
- Patient Medicare number
- Date(s) of service(s)
- Description of service or item
- Name of provider
- Provider Medicare number
- Address of provider

Post-Course Knowledge Assessment

Now it is time to take the Post-Course Knowledge Assessment to determine how much you have learned about Medicare fraud and abuse.

This Assessment will ask you to answer a total of 14 questions related to the content of this course. Please note that you will not be able to exit the Assessment once you enter it. You can navigate back and forth through the questions and change answers as often as you would like until you have finished the assessment.

Assessment feedback is given after you have answered all 14 questions. Correct answers to the questions will also be provided in the Assessment feedback.

You will have the option to print your "Progress Report" containing your Preliminary Knowledge Assessment and Post-Course Knowledge Assessment scores at the feedback screen. You may re-take the Post-Course Knowledge Assessment as often as you like.

Post-Course Knowledge Assessment

Which of the following is the correct definition(s) of Medicare fraud?

- Knowingly and willfully executing a scheme against the Medicare program
- Unintentionally executing a scheme against the Medicare program
- Unknowingly executing a scheme against the Medicare program
- All of the above

Define Medicare Abuse:

Which of the following options best describes Medicare abuse?

- Unintentionally violating Medicare guidelines and procedures
- Failing to meet professionally recognized standards of care for Medicare patients
- Unknowingly receiving payment for services for which payment should not be made
- All of the above

Has Medicare fraud or abuse occurred if a provider is misrepresenting a non-covered OR screening service as medically necessary?

- Yes
- No

Has Medicare fraud or abuse occurred if a provider is requiring Medicare beneficiaries to pay the 20% co-insurance after the service was performed?

- Yes
- No

Has Medicare fraud or abuse occurred if a provider is billing for services in excess of those needed by the patient?

- Yes
- No

Is the following an example of Fraud or Abuse?

A provider intentionally files duplicate claims to Medicare.

- Fraud
- Abuse

Is the following an example of Fraud or Abuse?

A provider billed for services as if they were his own which were actually performed by another entity that is not eligible for Medicare payments.

- Fraud
- Abuse

Provider's Liability:

Can a provider be fined, excluded from the Medicare program, or imprisoned for errors made by his/her staff?

- Yes
- No

Provider Liability:

Can Medicare hold a provider responsible for not following established Medicare guidelines and policies?

- Yes
- No

Penalties associated with Medicare Fraud and Abuse:

Choose the best answer to the following question. What can happen to you if you are found guilty of Medicare fraud?

- You can be fined.
- You can be imprisoned.
- You can be excluded from federal healthcare benefits programs.
- All of the above.

Safeguard Practices against Fraud and Abuse:

When implementing safeguard practices, I should keep the following in mind: (Choose all that are correct.)

- Ensure that all staff and/or billing agents who bill on my behalf understand the need for confidentiality of my Medicare provider number and pertinent provider information.

- Make sure that copies of orders/referrals for services/items furnished by other entities are maintained in the patient's medical records.

- Confirm that employee performance evaluation ratings are based on the number of claims filed rather than on claim accuracy.

- Make sure there is a process used which checks claim remittances after re-filing claims, not before.

When selecting a billing service, I should choose a service that:
(Choose all that are correct.)

- Charges me for their services based on the number of claims they file.
- Unbundles services so that increased payment can result.
- Guarantees the confidentiality of my Medicare provider number and other personal information.
- None of the above.

When selecting another provider/entity from which to order/refer services, ensure that: (Choose all that are correct.)

- The provider/entity is not sanctioned by the Medicare program.
- The provider/entity furnishes only the services/items that you order.
- The provider/entity furnishes and bills for services/items in addition to the services/items which you ordered.
- All of the above.

Choose the best answer to the following question. When applying safeguard practices to protect patients, I should consider the following:

- Ensure that health insurance claim numbers used to file claims are taken from the patient's red, white and blue Medicare card.

- When appropriate, shred or otherwise destroy reports which include patients' names and Medicare numbers.

- Confirm that the name on the Medicare card matches the patient's valid photo identification.

- All of the above.

You scored ___ correct on the Post-Course Knowledge Assessment.

Refer to the button bar below to see which questions you answered correctly or incorrectly. Click numbered button to view the correct response for each question. A green button indicates a correct answer. A red button indicates a correct answer.

1	2	3	4	5	6	7	8	9	10	11	12	13	14

Your course "Progress Report" containing both the Preliminary Knowledge Assessment and Post-Course Knowledge Assessment scores can be obtained by clicking the Print Button below. Fraud and Abuse course certification is given to individuals scoring 90% or better on the Post-Course Knowledge Assessment.

Note: You may increase your final score by retaking the Post-Course Knowledge Assessment at any time. Click the Menu button to do this now.

(End of Medicare Fraud and Abuse Section)

(End of Fraud and Abuse Section)

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